Health care systems in Europe

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Collector of Third-party payer resources

Steward/regulator

Regulation

Purchasing/contracting/financing providers

Providers

Access to and provision of services

Population


Mobilizing resources/funding

Resource pooling & allocation

Functions
Resource pooling & allocation

Collector of resources → Third-party payer

Mobilizing resources/funding

Steward/regulator

Regulation

Population Coverage Who? For what?

Access to and provision of services

Purchasing/contracting/financing providers

Providers

System typology
System typology

Third-party payer:
Sickness funds ( = SHI), government/health authorities ( = NHS) ...

Payer-provider relation: integrated ("classical" NHS), contractual (SHI, "new" NHS), none (PHI)

Collector of resources
Main funding source: contribution on wages ( = SHI), taxes ( = NHS), premium ( = PHI)

Steward/regulator

Population

Providers

SHI = Social health insurance
NHS = National Health Service
PHI = Private health insurance
The funding mix in 2002

¹: Data refer to 2001
²: based on calculations of Schreyögg (2000)
Countries with major changes in funding mix 1975 - 2002

²: based on calculations of Schreyögg (2003)
Tax-based systems in western Europe

http://mig.tu-berlin.de
Classical integrated NHS-type system

Central government

Population

General taxation

Limited choice

Public providers

NHS = payer & provider

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Central Regional governments

Development 2

Purchaser – provider split

General taxation

Population Limited choice Public providers

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Questions arising:
• Funding from national or regional taxation?
• Benefit catalogue uniform?
• Supply density and quality regulated uniformly?
• Access to services across regional borders?

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Regional governments

Population

Public providers

General taxation

Purchaser – provider split

Limited

more choice

(money follows patient)

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Development 4

Regional governments

General taxation

Purchaser – provider split

Population

Limited更多选择

Public providers: Public-private mix

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Social Health Insurance (SHI) or „Bismarckian“ countries in western Europe

Commonalities and variations between countries
What makes a health system a SHI system?

**Contribution collector**
- Not (health) risk-, but usually wage-related contribution
- [Choice of fund]

**Third-party payer**
- = sickness funds
- bipartite self-government

**Population**
- Mandatory insurance

**Providers**
- Public-private mix

**Limited government control**

**Contracts**

**Free access**
• SHI traditionally tied to employment, later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
• 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
• 65% coverage in Netherlands (no choice!)
• *pre-determined* membership in Austria, France and Luxembourg

• *free choice* of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland - *the young, well-educated and healthier are changing funds more often, i.e. risk-structure de-mixes!*
- Traditionally based on wages only (with an upper limit)
- Problem 1: increasing burden on labour costs as other income is rising faster - Solution: broaden income base, e.g. by abolishing upper limit (Belgium, France)
- in France change from wage-based contribution of 6.8% to tax of 6.0% on all income of insured + taxing of pharamaceutical advertising ... *i.e. relief for wage-earners*
Figure 4.2 Contributions at different income levels according to contribution rates in the four countries

- France (18.8%)
- Germany (14.3%)
- Netherlands (20.75%)
- Japan (8.6%)*
- Japan (8.5%)*
• Problem 2: inequity of contributions as income and risk profiles differ between funds
• Traditional approach: complete pooling of contributions and passing money to funds according to expenditure
• = conflict with efficiency goal and instrument “competition“
• *uniform* contribution rate in A, B, F, L and NL (but differing per-capita premium on top); *differing* rate in Germany; *differing* per-capita premium in Switzerland
• new approach: prospective allocation of resources (Belgium, Netherlands) or re-allocation (Germany, Switzerland) – *the latter is more difficult as sickness funds view money as “theirs“*

• differences in: area of allocation - nation vs. region (Switzerland), degree of retrospective compensation, factors in the formulas (e.g. region in NL), types of expenditure included, use of high-risk pool
### Number of sickness funds

<table>
<thead>
<tr>
<th>Year</th>
<th>A*</th>
<th>B*</th>
<th>CH</th>
<th>D*</th>
<th>F*</th>
<th>L*</th>
<th>NL</th>
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<tbody>
<tr>
<td>1992</td>
<td>26</td>
<td>127</td>
<td>191</td>
<td>1223</td>
<td>19</td>
<td>9</td>
<td>27</td>
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<tr>
<td>2002</td>
<td>24</td>
<td>100</td>
<td>93</td>
<td>355</td>
<td>18</td>
<td>9</td>
<td>24</td>
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</table>

* typical bi-partite government
• all SHI systems are traditionally multi-payer systems – problem: weak cost-control
• solutions: budgets – via state (Austria, France) or collective contracts (problem: contradict competition between funds)
• Netherlands: collective contracts are illegal – *but*: funds hardly use selective contracts and reimbursement at lower than maximum rates
Contribution collector

Payer

Insured

Provider

<table>
<thead>
<tr>
<th>Country</th>
<th>Public</th>
<th>Not-for-profit</th>
<th>For profit</th>
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</thead>
<tbody>
<tr>
<td>Austria</td>
<td>69%</td>
<td>26%</td>
<td>5%</td>
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<tr>
<td>Belgium</td>
<td>60%</td>
<td>40%</td>
<td></td>
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<tr>
<td>France</td>
<td>65%</td>
<td>15%</td>
<td>20%</td>
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<tr>
<td>Germany</td>
<td>54%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>14%</td>
<td>86%</td>
<td></td>
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</table>
• Free access = feature of SHI systems (except NL): Gatekeeping = more effective, cheaper, but less popular (also in NL)

• Attempts in the Netherlands to separate “core” benefits from others (to be paid for privately) has failed: dental care was partly re-introduced; not covered services make up only 3% of expenditure
Which system is “best“?

Answer depends on goals, i.e.

• Health gain/ improvement
• Responsiveness to population needs
• Sustainable funding
• Equity in health, responsiveness and funding
• Efficiency (reaching goals : resources)
060101 +Life expectancy at birth, in years

Cross-sectional vs. longitudinal

1. Sweden


Netherlands

Data: WHO-EURO
HfA-Data base 1/2004
Sufficient blood pressure control
6 months after a CHD hospitalisation

Data: EUROASPIRE „Clinical reality of coronary prevention guidelines“, Lancet 2001; 357: 998
<table>
<thead>
<tr>
<th>Country</th>
<th>2002</th>
<th>1990</th>
<th>Fairness (max. 1.00)</th>
<th>% of households which spend &gt;40% of income on health</th>
<th>% of households which spend &gt;40% of income out-of-pocket</th>
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<tbody>
<tr>
<td>Greece</td>
<td>47.1</td>
<td>46.3</td>
<td>0.858</td>
<td>3.29</td>
<td>2.17</td>
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<td>Switzerland</td>
<td>42.1</td>
<td>47.6</td>
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<tr>
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<tr>
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<tr>
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<tr>
<td>United Kingdom</td>
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<td>16.4</td>
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<td>Czech Republic</td>
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</table>
